STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155469	A. BUILDING _____ B. WING _____	03/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEBO'S NURSING AND REHABILITATION CENTER	4410 W 49TH AVE HOBART, IN46342

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: March 7, 8, 9, 10, 11 and 14, 2011 Facility number: 000366 Provider number: 155469 AIM number: 100288900 Survey team: Kathleen (Kitty) Vargas, RN, TC Lara Richards, RN Heather Tuttle, RN Janet Adams, RN Census bed type: SNF/NF: 119 Total: 119 Census payor type: Medicare: 16 Medicaid: 95 Other: 8 Total: 119 Stage II Sample: 39 These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2. Quality review completed on March 18,	F0000	Preparation and / or execution of this plan of correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because the provisions of federal and state laws require it. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation for substantial compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	2011 by Bev Faulkner, RN			

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F0156 SS=A	Based on record review and interview, the facility failed to ensure timely notice was given prior to discontinuing skilled nursing services for 1 of 3 residents reviewed for the discontinuation of skilled services of the 3 who met the criteria of being discharged from skilled nursing services in the sample of 39. (Resident #104) Findings include: On 3/11/11, the facility provided a list of residents whose skilled services were discontinued. Resident #104 was listed as having her skilled services discontinued on 3/8/11. The Admissions Coordinator provided a copy of the "Notice of Medicare Provider Non-Coverage" form for Resident #104. The form indicated the resident's skilled services were to end on 3/8/11. There was a receipt for certified mail that was sent to the responsible party, that was dated 3/8/11, the same day the skilled services ended. When interviewed on 3/11/11 at 12:30 p.m., the Admissions Coordinator, indicated she sent the responsible party the "Notice of Medicare Provider	F0156	**F 156 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** R 104 is no longer receiving skilled services since 3/8/11. No corrective action can be made for this resident. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents who receive skilled services have the potential to be affected by the same deficient practice. The Admissions Coordinator was in serviced on the importance of ensuring the “Notice of Medicare Provider Non-Coverage” form is sent to the responsible party at least 48 hours prior to the last day of Medicare skilled services. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Facility Interdisciplinary Team has been in serviced by the Corporate MDS Consultant on beneficiary notices The facility has designated a back up plan in the admissions coordinators absence to ensure that the “Notice of Medicare Provider Non-Coverage” form is sent to the responsible party at least 48 hours prior to the last day of Medicare skilled services. How	04/08/2011

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	Non-Coverage" form by certified mail on 3/8/11, the last day of Medicare covered services. She indicated the responsible party was not notified in a timely manner. When interviewed on 3/11/11 at 2:15 p.m., the Nurse Consultant indicated the responsible party is to be notified 48 hours prior to the last day of Medicare skilled services. She indicated Resident #104's responsible party was not notified timely of the last day of skilled services. 3.1-4(a)		the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; The Administrator/ designee will audit residents being discontinued from skilled services to ensure timely notification has been given. Any non-compliance issues the Administrator identifies will be addressed with the admissions coordinator. The Administrator /designee will present a summary of the audits to the Quality Assurance committee monthly for three months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed:** April 8,2011	

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F0166 SS=D	Based on observation, record review and interviews, the facility failed to ensure a resident's grievance was documented and filed according to the facility's policy for 1 of 1 residents reviewed for dignity in the sample of 39. The facility also failed to promptly notify the resident and/or responsible party of the outcome/resolution of the grievance related to missing clothing for 1 of 3 residents reviewed for personal property of the 4 who met the criteria for personal property in the sample of 39. (Residents #19 & #121) **Findings include:** **The current 12/04 Filing Grievances/Complaints policy provided by the Social Service Director on 3/8/11, indicated "Our facility will assist resident, their representatives (sponsors), family member, or appointed advocates in filing grievances or complaints when such request are made. Any resident, his or her representative (sponsor), family member or appointed advocate may file a grievance or complaint concerning treatment, medical care, behavior of other resident, staff member theft of property, etc., without fear of threat or reprisal in any form. The resident, or person filing the grievance and/or complaint in behalf of the resident, will be informed of the findings of the investigation and the actions that will be taken to correct any identified problems. Such report will be made orally by the**	F0166	F 166 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Social Services met with resident #121 to inquire on any concerns that have not been addressed, address any new concerns and had documented any such concerns on a grievance form. The family for resident #19 was re-contacted about the missing clothing items, they wish to replace the missing items and bring the receipts in. The facility will reimburse them for the expense. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All facility residents have the potential to be affected by the alleged deficient practice. Review of concern forms showed no other open concerns that could be addressed. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Social Services initiated a plan of bringing all concern forms to the daily Interdisciplinary Team meetings. All new and open concerns are reviewed with the IDT daily until resolution is complete.	04/08/2011

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	administrator, or his or her designee, within 5 working days of the filing of the grievance or complaint with the facility." **1. On 3/7/11 at 2:52 p.m., Resident #121 was observed in a Broda chair in his room. Interview at that time, with the resident, indicated that** when he asks staff something, they say they will tell his aide, but they do not do anything about it or they do not tell the aide. The resident indicated he feels ignored. The record for Resident #121 was reviewed on 3/9/11 at 11:00 a.m. The 12/11/10 quarterly Minimum Data Set (MDS) indicated the resident was alert and oriented times three and was understood and was able to understand. The resident did need assistance with his activities of daily living. Review of Social Service Progress Notes from 12/10 through 3/11 indicated there was no documentation of any behaviors or problems with the resident. Interview with the Social Service Director on 3/10/11 at 9:30 a.m., indicated she has had several conversations with the resident regarding his concerns of having to wait a long time for care. She indicated the resident has expressed to her that he feels he has to wait a long time for care like going back to bed after lunch, he feels like staff do not pay attention to him when he was talking. She also indicated that she has told him to tell staff that you want to lay down or to holler at them if they walk by and tell them that you would like to lay down. Further interview indicated that she had not documented any of these grievances/complaints on a grievance form, nor did she have documentation of a		Concerns must be addressed within 5 business days, any concern that cannot be addressed in this time frame will require documentation explaining planned resolution to the concern. How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Concerns are reviewed in each morning meeting. Any concerns not resolved within 5 business days will be presented to the Administrator/DON for resolution. A monthly log of concerns and resolution dates will be presented to the Quality Assurance Committee monthly for review. These reviews will remain on-going. Date by which systemic corrections will be completed is 4/8/2011.	

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	resolution for the resident. Further interview with the Social Service Director at that time, indicated she should have filled out a complaint form and documented the conversations she had with the resident regarding his feelings that staff do not pay attention to him.			

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F0166 SS=D	2. The family member of Resident #19 was interviewed on 3/9/11 at 8:45 a.m. She indicated that the resident had four sets of missing clothing that was reported to the facility some time ago. She also indicated the Social Service Director was aware of the missing clothing. She indicated she has never received a response related to the loss of the clothing. Interview with the Social Service Director on 3/10/11 at 10:30 a.m., indicated she had a grievance form dated 12/7/10 that indicated Resident #19's family had reported there were articles of missing clothing. Review of the form titled, "Concern/Compliment Form," dated 12/7/10, indicated the following articles of clothing were missing: 1 lavender 2 piece jogging suit 1 gray 2 piece jogging suit 1 navy blue 2 piece (blank) 1 blue/green 2 piece jogging suit 2 t-shirts The area on the, "Concern/Compliment Form" for "Investigation (please attach any interviews as needed" was blank.	F0166	F 166 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Social Services met with resident #121 to inquire on any concerns that have not been addressed, address any new concerns and had documented any such concerns on a grievance form. The family for resident #19 was re-contacted about the missing clothing items, they wish to replace the missing items and bring the receipts in. The facility will reimburse them for the expense. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All facility residents have the potential to be affected by the alleged deficient practice. Review of concern forms showed no other open concerns that could be addressed. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Social Services initiated a plan of bringing all concern forms to the daily Interdisciplinary Team meetings. All new and open concerns are reviewed with the IDT daily until resolution is complete.	04/08/2011

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	Interview with the Social Service Director on 3/10/11 at 10:30 a.m., indicated there was no documentation of an investigation documented on the "Concern/Compliment Form." The area on the "Concern/Compliment Form" for "Resolution" was signed by the Administrator and was dated 2/16/11. Interview on 3/10/11 at 1:15 p.m. with the Administrator who signed the grievance form indicated the grievance was obtained on 12/7/10 and the resolution was dated 2/16/11. The Administrator indicated at that time the resolution to the family's grievance was not prompt, the family should have been informed of the resolution within 5 days of filing the grievance. 3.1-7(a)(2)		Concerns must be addressed within 5 business days, any concern that cannot be addressed in this time frame will require documentation explaining planned resolution to the concern. How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Concerns are reviewed in each morning meeting. Any concerns not resolved within 5 business days will be presented to the Administrator/DON for resolution. A monthly log of concerns and resolution dates will be presented to the Quality Assurance Committee monthly for review. These reviews will remain on-going. Date by which systemic corrections will be completed is 4/8/2011.	

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F0241 SS=E	Based on observation, record review and interview, the facility failed to ensure the dignity of 3 residents in the sample of 39 was maintained during dining, for 2 of 2 meal services observed. (Residents #14, #45, and #108) Findings include: 1. On 3/7/11 at 12:00 p.m., Resident #108 was seated in her Broda chair at a table in the Daisy Lane dining room. The resident's lunch tray was placed in front of her. The lid was not removed at this time. There were two other residents seated at the resident's table at this time. They were being fed by two other staff members. At 12:06 p.m., the resident's tray remained covered in front of her. Five staff members were present in the dining room and assisting with feeding. At 12:16 p.m., the resident's tray was uncovered and a staff member started to feed her. The record for Resident #108 was reviewed on 3/14/11 at 10:00 a.m. The resident's diagnoses included, but were not limited to, change in mental status, history of depression, confused, unsteady gait, dementia,	F0241	F 241. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Residents #14, #45, and #108 are receiving assistance with their meals timely. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All facility residents have the potential to be affected by the alleged deficient practice. The facility has implemented and updated a dining room monitor schedule to ensure that residents receive and are assisted with their meals properly and timely. The facility has also updated the posted mealtime to accommodate maximum staff assistance. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?Nursing staff will be in-serviced on the importance of promoting care for residents in a manner and in an environment that maintains or enhances each resident’s dignity and respect in full recognition of his or her individuality with emphasis on: · Assisting a resident timely with their meals, i.e. residents seated at the same table must be able to eat together. · Assuring that all available staff can participate at meal times. · Use of the PA system to page for available staff	04/08/2011

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	dementia with depressive features, and vertigo. The Quarterly Minimum Data Set (MDS) Assessment, dated 12/28/10, indicated the resident was totally dependent on staff for eating. Interview with CNA #3 on 3/11/11 at 10:15 a.m., indicated the resident was a feed and was dependent on staff to be fed. Interview with LPN #2 on 3/11/11 at 10:17 a.m., indicated the resident had to be fed by staff. Interview with the Administrator on 3/14/11 at 11:30 a.m., indicated the resident should have been assisted with her meal in a more timely manner.		any time addition staff is needed to assure timely assistance. How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?Three days a week the DON/designee will monitor the dining room during rotating meal times to ensure that residents receive and are assisted with their meals properly and timely. The DON/designee will present a summary of the audits to the Quality Assurance committee monthly for three months. Thereafter, if determined by the QA committee, auditing and monitoring will be done quarterly and presented at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed**: 4/8/2011	

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F0241 SS=E	2. Residents were observed on 3/11/11 at 11:50 a.m., in the Rainbow Room eating lunch. There were fourteen residents in the room. Twelve residents were eating their meals. Ten residents were being assisted with feeding and two residents were independently feeding themselves. Resident #14 and Resident #45 were observed sitting at a table together. The two residents had not been served their meals. Continued observation indicated that at 12:05 p.m., two staff members had completed feeding two other residents. After the other residents had completed their meal, the two staff members obtained the trays for Resident #14 and Resident #45. At 12:07 p.m., staff began to feed the two residents, seventeen minutes after all the other residents seated in the dining room had their trays and were eating. The record for Resident #14 was reviewed on 3/14/11 at 9:05 a.m. The Quarterly MDS (Minimum Data Set) assessment with an assessment reference date of 12/21/10 indicated the resident was totally dependent on one staff person for eating and that she rarely or never is understood and	F0241	F 241. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Residents #14, #45, and #108 are receiving assistance with their meals timely. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All facility residents have the potential to be affected by the alleged deficient practice. The facility has implemented and updated a dining room monitor schedule to ensure that residents receive and are assisted with their meals properly and timely. The facility has also updated the posted mealtime to accommodate maximum staff assistance. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?Nursing staff will be in-serviced on the importance of promoting care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality with emphasis on: · Assisting a resident timely with their meals, i.e. residents seated at the same table must be able to eat together. · Assuring that all available staff can participate at meal times. · Use of the PA system to page for available staff	04/08/2011

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	rarely or never is able to understand. The resident's plan of care, dated 10/7/10, indicated the resident required total assist with activities of daily living due to weakness and cognitive loss. The record for Resident #45 was reviewed on 3/10/11 8:08 a.m. The Quarterly MDS with an assessment reference date of 2/19/11 indicated the resident was totally dependent on one staff person for eating, the MDS also indicated the resident's long and short term memory was not impaired and he was able to always understand and be understood. The resident's plan of care, dated 3/11/11, indicated the resident was dependent on staff for activities of daily living. Interview with Resident #45 at 1:30 p.m., on 3/11/11 indicated he is always fed last. Interview with the Administrator on 3/14/11 at 9:15 a.m., indicated the staff in the Rainbow Room should have requested additional staff assistance for the feeding of the two residents. He indicated the residents		any time addition staff is needed to assure timely assistance. How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?Three days a week the DON/designee will monitor the dining room during rotating meal times to ensure that residents receive and are assisted with their meals properly and timely. The DON/designee will present a summary of the audits to the Quality Assurance committee monthly for three months. Thereafter, if determined by the QA committee, auditing and monitoring will be done quarterly and presented at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed**: 4/8/2011	

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	should have been assisted with eating in a more timely manner. **3.1-3(t)**			

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F0244 SS=C	Based on interview and record review, the facility failed to ensure the residents were aware that their suggestions and recommendations concerning the rules of the facility could be voiced at anytime for 1 of 1 Resident Council President interviews. This had the potential to affect 119 residents who resided in the facility. **Findings include:** **During the interview with the Resident Council President on 3/9/11 at 2:00 p.m., the President indicated he did not know and could not truthfully answer if he was aware the residents could make suggestions about the rules to the facility and if the facility would act on these suggestions.** Review of the Resident Council Meeting minutes on 3/9/11 indicated there had not been information provided to the residents, during the meetings, related to the rules of the facility. Interview with the Activity Director, on 3/9/11 2:20 at p.m., indicated she has not discussed in the council meetings information regarding making suggestions about the rules of the facility or changing any of the rules in the facility, nor had she documented any type of that information. **Interview with the Administrator, on 3/10/11 at 12:45 p.m., indicated there was no documentation regarding the residents being informed that they could make suggestions**	F0244	**F 244 What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** The facility held an emergency resident council meeting on 3/24/2011 informing the residents that their suggestions and recommendations concerning the rules of the facility could be voiced at any time. The resident council president is currently in the hospital, upon readmission an additional meeting may be held. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** The facility will add to the agenda for the next resident council meeting and the next scheduled family meeting imforming residents and families that the facility will listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.**How the corrective action will be monitored to**	04/08/2011

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	about the rules in the facility. **3.1-3(l)**		**ensure the deficient practice will not recur, i.e. what quality assurance programs will be put into place;** The Administrator/Designee will monitor resident council concerns to ensure the concerns are responded to/resolved in a timely manner. In addition group grievance/recommendation will remain on the agenda of the resident council meeting. The Administrator/designee will randomly interview 5 residents every week to determine there knowledge of the group grievance/recommendation process, additional information will be provided to any resident unaware. The Administrator/designee will present a summary of interview results to the Quality Assurance committee monthly for six consecutive months or until compliance is met. **Date by which systemic corrections will be completed by 4/8/2011**	

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F0250 SS=D	Based on observation, record review, and interviews, the facility failed to provide medically-related social services related to not arranging for the medical clearance required for oral surgery for 1 of 1 residents reviewed for dental services in the sample of 39. (Resident #121) **Findings include:** **Interview with Resident #121 on 3/7/11 at 3:06 p.m., indicated his gums were sore sometimes and depending on what was served to eat he had some difficultly chewing his food, due to not having a lot of teeth.** **On 3/7/11 at 3:16 p.m., Resident #121 was observed sitting in a Broda chair in his room. At that time, the resident's teeth were observed to be decayed, chipped and broken. The resident was missing many of his teeth.** **The record for Resident #121 was reviewed on 3/9/11 at 11:00 a.m. The resident's diagnoses included, but were but not limited to, alcohol abuse, cirrhosis of the liver, and diabetes.** **Review of the 4/6/10 initial Minimum Data Set (MDS) assessment indicated the resident**	F0250	**F 250 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** R 121 was seen by the oral surgeon on 3/16/2011 for treatment. Medical clearance was obtained at the time. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents referred for oral surgery have the potential to be affected by the same alleged deficient practice. An audit of residents that were seen by the dentist since 1/1/2011 was completed to ensure that recommendations are completed, and any resident referred for oral surgery has medical clearance. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** The Social Service Department and clinical staff were in-serviced on 4/1/2011 regarding: Obtaining medical clearance timely for residents requiring oral surgery. Dental recommendations Oral surgery referrals and follow-up. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance	04/08/2011

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	was alert and oriented times three and was able to understand and was understood. The MDS indicated the resident had some/all natural teeth lost and does not have dentures. The resident has broken, loose, or carious teeth and daily cleaning of his teeth was provided by staff or the resident. The current plan of care, dated 4/7/10 and updated on 12/11/10, indicated the resident has broken, loose or carious teeth. The care plan goal was that the resident will not experience further tooth decay. The nursing approaches were to assess the condition of oral cavity, teeth, tongue, lips, provide staff assistance for oral hygiene, and obtain a dental consult. Review of the Dentist's visit indicated an initial visit was on 7/12/10. The Dentist recommended for the resident to see an oral surgeon. The Dentist indicated "Patient has multiple root tips with severe inflammation." Referral written, recommended by the dentist to extract all dentition and root tips		programs will be put into place; The Social Service Director/designee will audit dental recommendations to ensure the recommendations are addressed. The Administrator /designee will present a summary of the audits to the Quality Assurance committee monthly for three months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed:** April 8, 2011	

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	to see oral surgeon for X-ray and evaluation. The resident had an appointment set up and went to the oral surgeon on 7/15/10, however, he did not see the surgeon on that day and his appointment was rescheduled for 7/27/10. Interview with the ADoN (Assistant Director of Nursing) on 3/11/11 at 9:00 a.m., indicated she did not know why the resident did not see the oral surgeon on that day. The resident was admitted to the hospital on 7/23/10 and was readmitted back to the facility on 7/27/10, therefore, his appointment with the oral surgeon was canceled. The next dental visit was on 8/9/10 and again he recommended to see an oral			

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	surgeon and also indicated the resident had appointment with the oral surgeon on 8/10/10. The resident saw the oral surgeon on 8/10/10 and was waiting on medical clearance from his primary physician. The dentist then recommended on 8/24/10 for the resident to follow up with the oral surgeon. Interview with the ADoN on 3/11/11 at 9:00 a.m., indicated all of the resident's information was faxed to the oral surgeon on 8/24/10 and the surgeon would call the facility within three days. On 9/9/10, the oral surgeon requested labs be obtained for the resident. On 9/13/10,			

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	the completed laboratory work for surgery was faxed to the oral surgeon. The Dentist saw the resident on 9/21/10 and 10/18/10 and indicated the resident still had not seen the oral surgeon and made the recommendation to see the oral surgeon, and that the dentist recommends extraction of all teeth. On 11/18/10 the Dentist saw the resident and again indicated the resident still had not gone out for oral surgery. The Dentist indicated "patient states he wants his teeth out and to get dentures." The next Dental visit was on 1/13/11 which indicated "he says he does plan to go out to the oral surgeon." The last Dental visit was on 3/3/11, and indicated "talked to Social Service (name) today and			

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	patient has not gone out to oral surgeon. Did not see patient today." Interview with the Social Service Director on 3/10/11 at 9:55 a.m., indicated she had spoken to nursing staff a couple weeks ago, and they were waiting for the doctor to sign a medical clearance to get the surgery done. She indicated the resident needs to have his teeth surgically removed. Review of Social Service Progress notes, dated 10/10-3/11, indicated there was no documentation or any information regarding the oral surgeon and the need for the resident's teeth to be extracted. Review of Nurse's Notes,			

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	dated 11/10-3/11, indicated there was no documentation or information regarding the resident's need for his teeth to be extracted and the need to see the oral surgeon. Interview with the ADoN on 3/11/11 at 9:00 a.m., indicated on 11/18/10 the Oral Surgeon was waiting to speak to the resident's primary physician to obtain medical clearance for surgery. The ADoN further indicated at the time, that nursing staff should have followed up with the dentist's recommendations and the need for the resident to see the oral surgeon so his teeth could be extracted. 3.1-34(a)			

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F0253 SS=E	Based on observation and interview, the facility failed to ensure the residents' environment was clean and in good repair related to marred resident room walls, marred bathroom walls, rusty ceiling vents, discolored floor tile grout, gouged and marred furniture and odors in resident rooms for 5 of 5 hallways. This affected 34 residents in the population of 119 residents residing in 18 of 71 rooms, with the potential to affect all residents who lived in the facility. (Daisy Lane, Bakersfield, Apple Lane, Cherry Lane, Blueberry Lane, and Cherry Court) (Rooms 19, 20, 21, 23, 24, 29, 30, 4, 70, 33, 41, 44, 45, 47, 48, 50, 52, 57) **Findings include:** **The following was observed during the Environmental Tour on 3/11/11 at 11:30 a.m., on Apple Lane:** **a. The resident room walls were marred and discolored in Rooms 19, 20, 21, 23, and 24. There were two residents in each of those rooms except for Room 24 where only one resident resided.** **b. The door frames was marred in Rooms 21 and 24. Two residents resided in each of those rooms** **c. The ceiling had spillage observed on it in Room 20. Two residents resided in this room.**	F0253	**F253 What corrective actions will be accomplished for those residents found to have been affected by the deficient practice.** Apple Lane The spillage in the ceiling in room 20 was cleaned.The shower room on Apple lane had the following corrections made. The stains in the bathtub were cleaned The ceiling light bulbs were replaced. The foot section of the wall tile on the column in the second stall was repaired. The dried cement on the wall in the third stall was removed Therapy A therapy table has been ordered to replace the high-low table. Beauty Shop A quote has been accepted to replace the floor tile.The dryer heads in the beauty shop were cleaned. Bakersfield The chairs identified as marred and scuffed in the dining room were painted.The splash guard on the soiled utility door was cleaned.The furniture in the activity room was painted.The wood cabinets in the activity room were painted.The toilet paper roller in room 70 was replaced. Blueberry Lane The bathroom in room 41 was cleaned to remove the odor. Daisy Lane The dining room chairs have been replaced.The furniture in the dining room has been cleaned and painted.The floor register was painted.The ceiling vent in the hallway was painted.The grout in the floor tile was cleaned	04/08/2011

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	d. The Bath tub was dirty with stains noted on it in the shower room. The ceiling lights were burned out. The second stall in the main shower room was missing a one foot section of wall tile on the column. Dried cement was noted on the wall tile in the third stall. e. The entire wall below the chair rail on both sides of the hallway was dirty. **2. The following was observed on Cherry Court during the Environmental Tour on 3/11/11 at 11:00 a.m.:** **a. The wallpaper on both sides of the hall had areas that were torn below the chair rail throughout the entire hallway.** **b. The resident room walls and bathroom walls were marred in Rooms 29, and 30. There was two residents who resided in room 29 and one resident resided in room 30.** **3. The following was observed on Cherry Lane during the Environmental Tour on 3/11/11 at 11:00 a.m.:** **a. The wallpaper behind the resident's bed was torn in Room 4. The resident room walls were also marred. There were two residents who resided in this room.** **b.** The wallpaper on both sides of the hall had areas below the chair rail that were torn and dingy throughout the entire hallway. c. The high-low table mats were torn. The blue painted walls in the therapy room were marred and scratched.		for bathrooms 44, 45, 47, 48, 50, 52, and 57.The footboards in rooms 45 and 50 were repaired/repainted. Rainbow Room The chairs that were marred and scuffed were repaired. A contractor has been secured to repair/repaint resident rooms and/or bathroom walls of room #'s 4, 19, 20, 21, 23, 24, 29,30, 33, 41, 44, 45, 47, 48, 50, 52, 57; repaint/refinish doors and/or door frames for resident rooms, 21, 24, 44, 50, 52, 57 and common areas of the beauty shop, Bakersfield dining room and activity room; repair/paint the chapel; remove the wallpaper and repair/paint the walls in the beauty shop, Rainbow dining room, hallways on Apple Lane, Cherry Court, Cherry Lane, Blueberry Lane, Bakersfield and Daisy Lane; repair/paint the walls/ceiling in the Rainbow dining room; replace the wall guard at the Bakersfield nurses station, repaint the ceiling vents on Daisy Lane, Bakersfield, and the beauty shop. A contractor has been secured to replace the flooring in the beauty shop New chairs and furniture have been ordered for the Daisy dining room, Bakersfield dining room, Bakersfield activity room, and the Rainbow dining room.**How the facility will identify other residents having the potential to be affected by the same deficient practice and what**	

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	d. All the walls were marred in the Chapel. e. The Beauty Shop floor tile was chipped throughout in approximately two foot sections. The wallpaper was buckling on the walls and the walls were marred. The ceiling vent dusty and dirty. Two of four dryer heads were sticky and dirty. The door frame was marred gouged. **4. The following was observed on Bakersfield during the Environmental Tour on 3/11/11 at 11:00 a.m.:** **a.** The Nurses Station was missing the wall guard on one of its walls. The ceiling vent in the hallway was rusty. b. The outside of the dining room door was marred. Approximately 20 dining room chairs were marred and scuffed. All the walls were marred and paint chipped below the chair rail. The ceiling vent was rusty. c. The splash guard was dirty on the soiled utility room door. d. The furniture in the activity room was marred and scuffed. The three wood cabinets were marred and scuffed. The ceiling vent was rusty and the door frame was in need of painting. e. The toilet paper holder was missing in the Room 70. There were two residents who resided in this room. 5. The following was observed during the Environmental Tour on 3/11/11 at 11:00 a.m., on Blueberry Lane:		**corrective action(s) will be taken.** All facility residents have the potential to be affected by this deficiency. Housekeeping and Maintenance have been re-educated and in-serviced regarding this deficiency. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** The maintenance and housekeeping director/designee will complete rounds two times every week to ensure that the facility environment is maintained in a sanitary, orderly, and comfortable interior. The Maintenance Inspection Checklist and Housekeeping Daily Cleaning Schedule will be completed with rounds twice weekly. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance programs will be put into place.** The Administrator/designee will present a summary of audit findings to the Q/A committee monthly for review for three months and until compliance is met. **Date by which systemic corrections will be completed is 4/8/2011.**	

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a. The resident and bathroom walls were marred in Rooms 33 and 41. There were two residents who resided in these rooms.

b. The wallpaper below the chair rail on both sides of the entire hallway was discolored and torn.

c. There was an urine odor in the bathroom of Room 41. There were two residents who resided in this room.

6. The following was observed during the Environmental Tour on 3/11/11 at 11:00 a.m. on the Daisy Lane

a. The walls were marred below the chair rail on both sides of the entire hallway.

b. The walls were marred and discolored in the Daily Lane dining room. The seven dining room chairs were discolored, marred and scuffed. The furniture (the cabinets and tv stand) in the dining room was dirty, scuffed and marred and in need of repair. The floor register was marred.

c. The ceiling vent was rusty in the hallway.

d. The resident and bathroom room walls were marred in Rooms 44, 45, 47, 48, 50, 52, and 57. The grout on the floor tile in the resident bathrooms was discolored. There were two residents who resided in each of these rooms.

e. The bathroom, closet, and room doors were marred in Rooms 57, 44, 50, and 52. There were two residents who resided in each of these rooms.

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	f. The footboards were marred and scuffed in Rooms 45 and 50. There were two residents who resided in each these rooms. g. The walls were marred below the chair rail in the Rainbow Room. There were four chairs that were marred and scuffed. There was a six foot section of the ceiling that was water stained. The paint was also noted to be peeling in those areas. The door frame was chipped and scratched. Interview with the Maintenance Director on 3/11/11 at 12:40 p.m., indicated all the above was in need of repair or cleaning. **3.1-19(f)**			

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	155469	A. BUILDING _____ B. WING _____	03/14/2011

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F0280 SS=D	Based on observation, record review and interview, the facility failed to ensure the plan of care had been revised to reflect the current status of 2 of 26 residents whose care plans were reviewed in the sample of 39 related to splint application or Foley catheter removal. (Residents #42 and #121) Findings Include: 1. On 3/8/11 at 1:45 p.m. and 3:42 p.m., Resident #42 was observed in her in room in bed. The resident's right hand was closed in a fist and her left arm was underneath the blanket. The resident did not have a splint in place to her right hand. On 3/9/11 at 8:15 a.m., 9:25 a.m., and 10:55 a.m., the resident was observed in her room in bed. There was no splint to the resident's right hand and the resident's left hand was underneath the blanket. At 1:00 p.m., the resident was seated in a wheelchair in her room. The resident did not have any hand splints in place. The Record for Resident #42 was reviewed on 3/8/11 at 3:30 p.m.	F0280	**F 280 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The care plan for R42 has been updated to address the resident removing her splints. In addition the resident and the family have been educated regarding the risks associated with removing and failing to wear splints. The care plan was updated for R121 to address the resident's refusal to remove the foley catheter. In addition the physician has updated his progress notes to reflect the resident's refusal of the foley catheter. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents requiring splint application or removal of a foley catheter have the potential to be affected by the same alleged deficient practice.The interdisciplinary care plan team was re-inserviced by the MDS/Care Plan Consultant 3/29/2011 with an emphasis given on the importance of ensuring the residents' plan of care is updated and reflective of: 1. The residents' refusal of required splint application and associated risks. The residents' refusal to remove a foley catheter and associated risks.	04/08/2011

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	The plan of care, dated 1/17/11, indicated the resident required splint/brace assistance to her bilateral hands 6-7 times per week. The interventions indicated the following: Monitor for presence of pain, intolerance, or muscle spasm during range of motion. Provide passive range of motion to bilateral hands prior to splint application 6-7 times per week. Use splint to bilateral hands on in A.M. off in P.M. 6-7 times per week. Inspect skin to bilateral hands prior to each application and after each removal of splints 6-7 times a week. Observe and report any red or broken areas. Interview with Restorative CNA #1 on 3/9/11 at 3:30 p.m., indicated the resident has a history of removing her splints shortly after they are applied. She further indicated when the resident removes her splints that she documents that information on the back of the restorative sheet.		Review of physician progress notes to include documentation of resident refusal. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** The Restorative Nurse/designee will audit the restorative documentation sheets weekly to ensure that information documented by the restorative CNA such as splint refusals is updated in the resident's care plan and education regarding the risks of splint refusal is alsoincluded. The DON/designee will audit telephone orders that indicate discontinuation of the foley catheter. In the event the resident refuses to remove the foley catheter the care plan will be updated which will include the risk of prolonged use and the physician progress notes will be reviewed to ensure documentation is in place. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; The Restorative nurse/designee will present a summary of the restorative documentation sheet audit to the Q/A committee monthly for six consecutive months and then ongoing until compliance is met. The DON/designee will present a	

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	The resident's current plan of care did not address the resident removing her splints. The resident care card indicated bilateral resting hand splints were to be used and they were to be applied in the a.m. and removed in the p.m. Documentation on the care card indicated the resident frequently removed the splints and they were to be reapplied as needed. Interview with the Restorative Nurse on 3/9/11 at 3:35 p.m., indicated the resident continuously takes off her splints. Further interview at 4:23 p.m., indicated the resident's current care plan did not address the resident taking off her splints and the care plan needed to be updated.		report summary of audit findings related to the refusal to remove a discontinued foley catheter and review of physician progress notes to the Q/A committee monthly for six consecutive months and then ongoing until compliance is met. **Date by which systemic corrections will be completed:** 4/8/2011	

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F0280 SS=D	2. Resident #121 was observed on 3/9/11 at 2 p.m. The resident was seated in a Broda chair, the resident had a Foley catheter. The record for Resident #121 was reviewed on 3/9/11 at 11:00 a.m. The resident's diagnoses included, but were not limited to, kidney failure and history of prostate surgery. Physician orders, dated 8/24/10, indicated to discontinue the Foley catheter. Review of Nurse's Notes, dated 8/24/10, indicated the resident refuses removal of the Foley catheter. Further review of nursing progress notes indicated the resident was explained the consequences of keeping the Foley catheter. On 8/25/10, the resident's physician was notified of the resident's refusal of discontinuing the Foley catheter. Review of Physician Progress Notes, dated 8/10-3/11, indicated there was no documentation of the resident's refusal of the Foley catheter. The 7/6/10 plan of care, updated on 12/23/10, indicated the resident requires an indwelling Foley catheter related to diagnoses (dx): (blank). The nursing approaches were to	F0280	**F 280 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The care plan for R42 has been updated to address the resident removing her splints. In addition the resident and the family have been educated regarding the risks associated with removing and failing to wear splints. The care plan was updated for R121 to address the resident's refusal to remove the foley catheter. In addition the physician has updated his progress notes to reflect the resident's refusal of the foley catheter. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents requiring splint application or removal of a foley catheter have the potential to be affected by the same alleged deficient practice.The interdisciplinary care plan team was re-inserviced by the MDS/Care Plan Consultant 3/29/2011 with an emphasis given on the importance of ensuring the residents' plan of care is updated and reflective of: 1. The residents' refusal of required splint application and associated risks. The residents' refusal to remove a foley catheter and associated risks.	04/08/2011

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	assess drainage, record amount type color, odor, and observe for leakage. Nursing staff were to report urinary tract infection symptoms, change catheter per physician order, and position bag below level of bladder. The care plan did not address the resident's refusal for removing the Foley catheter. Interview with Assistant Director of Nursing (ADoN) on 3/10/11 at 9 a.m., indicated the resident refuses for staff to remove the Foley catheter. She further indicated the resident's care plan did not reflect the resident's refusal to remove the Foley catheter. 3.1-35(d)(2)(B)		Review of physician progress notes to include documentation of resident refusal. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** The Restorative Nurse/designee will audit the restorative documentation sheets weekly to ensure that information documented by the restorative CNA such as splint refusals is updated in the resident's care plan and education regarding the risks of splint refusal is alsoincluded. The DON/designee will audit telephone orders that indicate discontinuation of the foley catheter. In the event the resident refuses to remove the foley catheter the care plan will be updated which will include the risk of prolonged use and the physician progress notes will be reviewed to ensure documentation is in place. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; The Restorative nurse/designee will present a summary of the restorative documentation sheet audit to the Q/A committee monthly for six consecutive months and then ongoing until compliance is met. The DON/designee will present a	

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			report summary of audit findings related to the refusal to remove a discontinued foley catheter and review of physician progress notes to the Q/A committee monthly for six consecutive months and then ongoing until compliance is met. **Date by which systemic corrections will be completed:** 4/8/2011	

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F0282 SS=D	Based on observation, record review, and interviews, the facility failed to ensure Physician orders were followed as written related to antiembolytic stockings (TED hose) and the application of a PRAFO boot. The facility also failed to follow the resident's plan of care related to providing oral care and ensuring documentation of skin integrity for 1 of 3 residents reviewed for Activities of Daily Living (ADL) care of the 9 residents who met the criteria for ADL care in the sample of 39. (Resident #121) **Findings include:** On 3/7/11 at 3:07 p.m., during an interview with Resident #121, he indicated that staff do not provide oral care for him. He indicated there was a toothbrush in the drawer, but no one helps him. He also indicated at the time, they have the sponge swabs, but no one gives him those to use, he said, "The toothbrush hurts my teeth sometimes." Further interview with the resident, indicated he does not remember the last time, any staff member or himself brushed his teeth. He said, "It was a long time ago." The resident further indicated that he not been offered mouthwash either. At that time, the resident was observed sitting in a Broda chair in his room. The resident's teeth were noted to be discolored, decayed and broken. The resident had many missing teeth. The resident was also observed with scratches and abrasions to his chin area and	F0282	**F282 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The TED hose stocking for R121 were discontinued on 3/11/2011. The physicians order for the PRAFO boots for R121 was clarified on 3/14/2011. PRAFO boots are to be worn when resident is transferred out of bed and is up in the Broda chair. The abrasions to R121 face sustained while shaving himself are resolved. R121 is receiving routine set up for oral care. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents have the potential to be effected by the same alleged deficient practice. The facility has identified all resident with physician orders for TED hose. The facility has identified all resident with physician orders for PRAFO boots. All residents are identified as having the potential to have altered skin integrity. All residents are identified as requiring oral care. Nursing staff has been re-inserviced by DON/ADON regarding the following: Following the physician orders for TED hose and PRAFO boots Completion of oral care daily for all residents and providing	04/08/2011

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	lower cheeks. The resident indicated at that time, they were from shaving. On 3/8/11 at 2:15 p.m., the resident was brought into the main dining room. The was wearing black shoes and plain socks, there were no TED hose on his feet. His teeth were noted to be decayed and he had small abrasions to his face around his chin area and lower cheeks. There was no PRAFO boot observed to either one of his legs. On 3/9/11 at 9:40 a.m., the resident was observed in bed. The resident indicated his teeth still had not been brushed with morning care or before he has gone to bed. On 3/9/11 at 2:15 p.m., the resident was observed up in a Broda chair, in activities, At that time, there was no PRAFO boot noted to either one of his legs, nor was he wearing any TED hose. On 3/10/11 at 10:40 a.m., CNA #1 entered the room to get the resident out of bed for a shower. The CNA was asked about how often she provided oral for the resident and when does she brush the resident's teeth. She indicated at the time, that she has not and does not brush his teeth at all during morning care because "he can do it himself." The CNA then opened the bedside drawer and there in a pink basin was the resident's toothbrush in a sealed wrapper. The toothbrush wrapper was not opened. At that time, the resident was observed laying in the bed. The resident was then asked if the CNA has ever given him a toothbrush or paste to brush his teeth and he indicated "no." The CNA also indicated at the time, that she has not given him his toothbrush or the paste so		assistance if needed. Notification to the charge nurse and physician for any resident with altered skin integrity. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** The DON/designee will conduct rounds 3x/weekly to observe that physician orders are being followed for residents identified with TED hose and PRAFO boots, in addition the DON will observe for alterations in skin integrity (such as abrasions from shaving) to ensure the charge nurse and physician have been notified and the skin condition is addressed. The DON/designee will complete random interviews with 7 residents weekly to ensure that oral care is being completed and assistance is provided when needed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** The DON will present a summary of interview findings to the Q/A committee monthly for six consecutive months and then ongoing until compliance is met. The DON/designee will present a summary of observational round findings to the Q/A committee monthly for six consecutive months and ongoing until compliance is met. **Date by**	

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	he could brush his teeth, she said, "he has bad teeth." The resident who was still laying in the bed during this conversation, then indicated that he has not been given anything to brush his teeth, he also indicated that he has to be set up to brush his teeth and cannot remember when his teeth was last brushed. The CNA also indicated that she has not put on his TED hose all week because he refuses to wear them because they were too tight on his legs, she said she has let the nurse know that he refused them. She also indicated he refused to wear the PRAFO boot to his right foot/leg because of it being too tight as well, and she has let the nurse know that information also. Further interview with CNA #1 on 3/10/11 at 10:40 a.m., indicated she was aware the resident had those abrasions to his face after his shave on Monday. She indicated at that time, that she was not the CNA who shaved the resident on Monday after his shower. The CNA indicated that she did not report the skin condition to the nurse either. The record for Resident #121 was reviewed on 3/9/11 at 11:00 a.m. Review of Physician orders, dated 1/3/11 and on the current 3/11 recap, indicated TED hose. Another Physician's order dated 2/8/11 and on the current 3/11 recap indicated PRAFO boot to right lower extremity and was to be worn during transfers and while sitting in the Broda chair. Review of the 1/11 and 2/11 Medication Administration Record (MAR) indicated the TED hose was signed out as being on the resident with no documentation the resident		**which systemic corrections will be completed** 4/8/2011	

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	refuses to wear them. Review of the 3/11 MAR, indicated the TED hose were signed out as being on the resident in the morning and off at night with no documentation of refusals. The last documented signature was for the day shift on 3/10/11. Review of the 3/2/11 plan of care indicated the resident was at risk for (or for additional) alteration in skin integrity related to kidney failure, CHF, etc...very fragile skin, refuses to turn. The nursing approaches were to keep skin clean and dry, observe skin daily with ADL care and for any changes such as redness, bruising, break in skin, tender areas, and report to the nurse. Review of Nursing Progress Notes, dated 3/7, 3/8, and 3/9/11, for all three shifts indicated there was no documentation regarding the scabbed areas around his chin area or lower cheeks. The current plan of care, dated 4/7/10 and updated on 12/11/10, indicated the resident has broken, loose or carious teeth. The care plan goal was that the resident will not experience further tooth decay. The nursing approaches were to assess the condition of oral cavity, teeth, tongue, lips, provide staff assistance for oral hygiene, and obtain a dental consult. **Interview with LPN #2 on 3/14/11 at 9:00 a.m., indicated she was unaware the resident had obtained the abrasions to his chin area and cheek area from shaving on Monday. She indicated she was not informed of the areas. The LPN further indicated that she was not made aware the resident was refusing to wear his TED hose and PRAFO boot. The**			

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	LPN indicated she had worked last Monday and Wednesday and was the regular floor nurse during the day on that hallway. Interview with the Assistant Director of Nursing on 3/11/11 at 9:00 a.m., indicated the expectations of the CNA were to inform the nurse on duty if the resident refuses anything and to let the nurse know if there was a problem with the resident's skin integrity. 3.1-35(g)(2)			

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F0309 SS=D	Based on observation, record review, and interviews, the facility failed to provide the necessary care and services to ensure a resident who required assistance with activities of daily living was transferred using the proper technique so that the resident did not experience any pain for 1 resident in the sample of 39. (Resident #121) Findings include: On 3/7/11 at 3:07 p.m., Resident #121 was interviewed. He **indicated that staff do not listen to him when he requests items. The resident indicated staff do not always use the "lift" to transfer him from the bed to the chair. He indicated if the mechanical lift was not used it causes him to have pain in his legs and feet.** On 3/10/11 at 10:40 a.m., CNA #1 entered the resident's room The CNA was asked how she transfers the resident from the bed to the chair. The CNA indicated that she transfers him by herself or sometimes with the help of another CNA, because he can stand and use his legs. The CNA indicated that she has never used the mechanical lift for his transfers. CNA #1 then left the room to get another CNA to help her get the resident out of bed. Interview with the resident at that time, after the CNA left the room, indicated he needed the mechanical lift to get out of bed, because "it hurts my feet when I transfer from the bed	F0309	**F309** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** R121 is currently being transferred with the use of the sit to stand mechanical lift. The CNA's responsible for completing that transfer were immediately re-inserviced when the facility was notified of the manual transfer. In addition the physician will review the resident for additional pain management. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents have the potential to be effected by the same alleged deficient practices. Nursing staff has been re-inserviced regarding the following: Use of care cards for transfers to ensure the correct transfer is performed. Types of transfers, and conducting safe transfers Notification of the charge nurse with any complaint or observation of pain such as facial grimacing. **What measures will be put into**	04/08/2011

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	to the chair." The CNA then came back to the room with another CNA. Both CNAs pulled the resident to the side of the bed and lifted under his armpits and pulled him to a standing position. The resident was able to stand while holding onto both of the aides. The resident was then observed grimacing with his face, his eyes were closed while standing and while trying to move his right and left legs backwards to the chair. The resident's legs were then observed to be trembling while trying to move them towards the Broda chair. The resident was then seated into the Broda chair. After being seated into the chair, he was then instructed by CNA #1 to push himself backwards in the chair so that he could reposition himself. The resident then pushed down with both of his hands on the armrests and pushed himself backwards. As he did this, again his face was observed with a grimace, both of his legs were noted again to be trembling as he pushed downward and he grunted out loud while pushing himself backwards. During that time, both CNAs did not help him. Interview with CNA #1 on 3/10/11 at 12:10 p.m., indicated she was then asked about the resident's pain in his legs and feet during the transfers to the chair from the bed, the CNA indicated she was aware of the resident's pain in his legs and feet during those transfers from the bed to the Broda chair, she stated, "I know he has told us that too, some days it is ok and other days it is bad." The record for Resident #121 was reviewed on 3/9/11 at 11:00 a.m. The resident's diagnoses included but were not limited to, kidney failure, cellulitis of bilateral lower extremities, congestive heart failure, history of		**place or what systemic changes will be made to ensure that the deficient practice does not recur;** The restorative nurse/designee will observe 5 resident transfers every week to ensure resident's transfers are conducted safely as indicated on the care card and pain is managed during transfers. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** The restorative nurse/designee will present a summary of transfer observations to the Q/A committee monthly for six consecutive months and ongoing until compliance is met. **Date by which systemic corrections will be completed** 4/8/2011	

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	back surgery, history of groin surgery, history of prostate surgery, cirrhosis of liver, alcohol abuse, high blood pressure, stroke, arthritis, depression, and failure to thrive. Review of the 12/11/10 quarterly Minimum Data Set (MDS) assessment indicated the resident was understood and able to understand, he was alert and oriented times three with no mood or behaviors noted. The resident's ADL ability was that he needed extensive assist with two person physical assist with transfers and he was totally dependent on staff for locomotion on and off of the unit. Review of the initial MDS assessment, completed 4/6/10, indicated the resident was alert and oriented times three. The resident's ADL ability indicated he needed extensive assist with a two person physical assist with transfers. Review of the Medication Administration Record (MAR) for the month of 3/11 indicated the resident has an order for acetaminophen 325 milligrams (mg) two tablets orally every 4 hours as needed for pain. The medication was signed out one time on 3/8/11 at 11:20 p.m., for resident complaints of generalized pain. Review of the care card that was inside the resident's closet door indicated the resident was limited assist with all transfers. Review of the Restorative Nursing Assessment, completed on 2/28/11, indicated the resident was dependent on staff for ADL care, bed mobility and transfers.			

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	Interview with the Restorative Nurse on 3/10/11 at 11:40 a.m., indicated the resident was receiving restorative care for bed mobility and active range of motion. She also indicated the resident required the "Sara lift" (a lift that still enables the resident to stand but does not bear weight on the resident's legs or feet) for transfers because he was an extensive assist for transfers and it was safer to use the lift because two staff members can cause "boo boos." After reviewing the old care card with the Restorative Nurse at that time, she indicated the information on the card was inaccurate. A new care card as well as a new restorative assessment for the resident was then completed by the Restorative Nurse on 3/10/11. She indicated the resident was to be a Sara lift only and needed "set up" assistance with brushing teeth and washing his face. Interview with the Restorative Nurse at 1:20 p.m., on 3/10/11 indicated the resident prefers to use the Sara lift. She also indicated the resident had told her that all other CNAs use the Sara lift for him during transfers except for CNA #1. 3.1-37(a)			

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F0312 SS=D	Based on observation, record review, and interviews, the facility failed to ensure a resident who was able to perform some of his activities of daily living received the necessary treatment and services to maintain them related to providing oral care for 1 of 3 residents reviewed for activities of daily living of the 9 residents who met the criteria for activities of daily living in the sample of 39. (Resident #121) Findings include: On 3/7/11 at 3:07 p.m., during an interview with Resident #121 he indicated that staff do not provide oral care for him. He indicated there was a toothbrush in the drawer, but no one helps him. He also indicated at the time, they have the sponge swabs, but no one gives those to him to use, he said, "The toothbrush hurts my teeth sometimes." Further interview with the resident, indicated he does not remember the last time, any staff member or himself brushed his teeth. He said, "It was a long time ago." The resident further indicated that he not been offered mouthwash either. At that time, the resident was observed sitting in a Broda chair in his	F0312	**F 312** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** R 121 was provided with set up assistance with oral hygiene and mouthwash and mouth swabs were provided. In addition the oral surgeon on 3/16/2011 saw the resident. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All facility residents who are dependent on staff to provide or assist in oral hygiene have the potential to be affected by the same deficient practice. An audit of residents who are dependent on staff to provide some or all of oral care assistance was completed. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** The DON/designee will conduct rounds 3x/weekly to observe that oral hygiene is completed. Nursing staff was in serviced on	04/08/2011

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	room. The resident's teeth were noted to be discolored, decayed and broken. The resident had many missing teeth On 3/9/11 at 9:40 a.m., the resident was in bed, at that time, the resident indicated his teeth still had not been brushed during the day or at night time. On 3/10/11 at 10:40 a.m., CNA #1 entered the room to get the resident out of bed for a shower. The CNA was asked how often she provided oral for the resident and when does she brush the resident's teeth. She indicated at the time, that she has not and does not brush his teeth at all during morning care because "he can do it himself." The CNA then opened the bedside drawer and there in a pink basin was the resident's toothbrush in a sealed wrapper. The toothbrush wrapper was not opened. At that time, the resident was observed laying in the bed. The resident was then asked if the CNA has ever given him a toothbrush or paste to brush his teeth and he indicated "no." The CNA also indicated at the time, that she has not given him his toothbrush or the paste so he could brush his teeth, she said, "he has bad teeth." The resident who was still laying in the bed during this conversation, then indicated that he has not been given anything to brush his teeth, he also indicated that he has to be set up to brush his teeth and cannot remember when his teeth was last brushed. The record for Resident #121 was reviewed on 3/9/11 at 11:00 a.m. The resident's diagnoses included but were not limited to, kidney failure, cellulitis of bilateral lower		4/1/2011 regarding the following: Proper oral hygiene techniques Equipment needed and set up for proper oral hygiene. When to provide/ set up oral hygiene How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; The DON/designee will complete random interviews with 7 residents weekly to ensure that oral care is being completed and assistance is provided when needed. The DON/designee will present a summary of the audits to the Quality Assurance committee monthly for three months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed:** April 8, 2011	

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	extremities, congestive heart failure, history of back surgery, history of groin surgery, history of prostate surgery, cirrhosis of liver, alcohol abuse, high blood pressure, stroke, arthritis, depression, and failure to thrive. Review of the 12/11/10 quarterly Minimum Data Set (MDS) assessment indicated the resident was understood and able to understand, he was alert and oriented times three with no mood or behaviors noted. The resident's ADL ability was that he needed extensive assist with a one person physical assist with dressing and personal hygiene. Personal hygiene included combing the resident's hair, and brushing his teeth, as well as shaving. Review of the initial MDS assessment, completed 4/6/10, indicated the resident was alert and oriented times three. The resident's ADL ability indicated he needed extensive assist with personal hygiene and required a one person physical assist. The resident also had many of his natural teeth missing and did not have dentures. The resident had broken, loose or carious teeth. The current plan of care, dated 7/6/10 and updated 12/10, indicated the resident was limited in ability to maintain grooming and personal hygiene related to his physical ability. The goal was the resident will be well groomed. The nursing approaches were to asses resident's motor function, sensation, and reflexes in all extremities, assess resident's cognitive status, attitude toward dependence, and motivation in participate in care and monitor him for pain. The current plan of care, dated 4/7/10 and			

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	updated on 12/11/10, indicated the resident has broken, loose or carious teeth. The care plan goal was that the resident will not experience further tooth decay. The nursing approaches were to assess the condition of oral cavity, teeth, tongue, lips, provide staff assistance for oral hygiene, and obtain a dental consult. Review of the ADL flow sheet for 3/11 indicated oral care was signed out as being completed 3/1-3/9 during the day shift. Oral care was signed out as being completed on the 3-11 shift on 3/1, 3/2, and 3/7. The midnight shift only had documented that they completed oral care on 3/10/11. Review of the care card that was inside resident's closet door, indicated the resident was total assist with grooming. Review of the Restorative Nursing Assessment, completed on 2/28/11, indicated the resident was dependent on staff for ADL care, bed mobility and transfers. The resident needed limited assistance with bathing his face and extensive assist with bathing his upper body and required set up with equipment. Interview with the Restorative Nurse on 3/10/11 at 11:40 a.m., indicated the information on the resident's care card was inaccurate. A new care card as well as a new restorative assessment for the resident was then completed by the Restorative Nurse on 3/10/11. She indicated the resident needed "set up" assistance with brushing teeth and washing his face.			

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	3.1-38(a)(3)(C)			

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F0356 SS=C	Based on observation and interview, the facility failed to post the staffing sign at the beginning of each shift everyday. The had the potential to affect 119 residents who resided in the facility. **Findings include:** On 3/8/11 at 11:45 a.m. and 4:30 p.m. the staffing sign was observed posted on the wall in the foyer area of the facility. Further observation indicated the date on the staffing sign was 3/7/11. On 3-11-11 at 11:00 a.m. and 4:00 p.m., the staffing sign was posted on the wall in the foyer area. Further observation indicated the date on the staffing sign was 3/9/11 (two days earlier). Interview with the Director of Nursing (DoN) on 3/14/11 at 9:40 a.m., indicated another employee who was the scheduler was responsible for posting the staffing sign everyday. The DoN further indicated the scheduler had only worked last Friday, Saturday and Sunday. The DoN indicated at the time, that she was unaware the staffing sign had to be posted at the beginning of each shift. 3.1-13(a)	F0356	**F 356 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The facility currently has nurse staffing data sheets posted at the beginning of the dayshift. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents have the have the potential to be affected by the deficient practice. The facility hired a new full time scheduler who will be responsible for ensuring that daily the nurse staffing data will be posted at the beginning of the dayshift. An audit of nurse daily staffing sheets was completed to ensure the facility has one for each day this month. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** The scheduler will be responsible to ensure that daily the nurse staffing data will be posted at the beginning of the dayshift. Monday thru Friday the scheduler will post the nurse staffing data. On the weekends the receptionist will post the nurse staffing data. In the absence of the schedule the Director of Nursing will ensure the nurse datastaffing sheet is posted. The scheduler,	04/08/2011

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			receptionist, and Director of Nursing was in serviced on the nurse staffing data with emphasis given on: · posting the sheet every day · posting the sheet at the beginning of the dayshift How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; Three days a week the DON/ Designee will monitor to ensure that the current nurse staffing data are posted at the beginning of the dayshift. The DON/designee will present a summary of the audits to the Quality Assurance committee monthly for three months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed:** April 8, 2011	

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F0371 SS=E	Based on observation and interview, the facility failed to ensure that 25 tray cover lids were not stacked wet after being washed. This had the potential to affect 25 of 114 residents who were receiving oral diets throughout the facility. Findings include: On 3/11/11 at 2:10 p.m., during the Kitchen Sanitation Tour with the Dietary Food Manager, a rack of dishes that was covered with plastic, was observed in the corner of the kitchen. The plastic cover had an accumulation of condensation on the inside. When uncovered, 25 tray cover lids had been stacked on top of each other. When lifted up, there was moisture between each lid. Interview with the Dietary Food Manager at the time, indicated the lids should not have been stacked wet on top of each other. 3.1-21(i)(3)	F0371	**F 371** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The tray coverlids were completely dried before stored. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents who receive meal trays from the kitchen have the potential to be affected by the same deficient practice. The staff member who incorrectly stored the tray covers lids was individually in serviced. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** The Food Service Manager/designee re-inserviced the dietary staff on 4/3/2011 regarding the importance of ensuring that tray cover lids and dishes are completely dried before being stored. The Food Service Manager/ designee will discuss with the dietary staff potential concerns when tray cover lids and other dishes are stored wet on top of each other.	04/08/2011

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			How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; The Food Service Manager/designee will audit the lids to ensure they are dried completely before being stored at least weekly by and follow up with any concerns identified. The Food Service Manager/designee will present a summary of the audits to the Quality Assurance committee monthly for three months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed:** April 8,2011	

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F0406 SS=D	Based on observation, record review and interview, the facility failed to ensure specialized communication rehabilitative services were provided for 1 of 3 residents with a diagnosis of mental retardation, in a sample of 39. (Resident #3) Findings include: Resident #3 was observed on 3/11/11 at 7:15 a.m., eating breakfast. The resident provided eye contact when spoken to, but did not respond verbally. Resident #3's record was reviewed on 3/11/11 at 9:00 a.m. The resident had diagnoses that included, but were not limited to, cerebral palsy, mental retardation and seizure disorder. The Annual MDS (Minimum Data Set) assessment with the assessment reference date of 2/19/11 indicated the resident was rarely or never understood, rarely or never was able to understand and had no speech. The plan of care, dated 2/25/11, indicated the resident has difficulty understanding others and making self understood related to mental retardation and cerebral palsy	F0406	**F 406** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** R 3 was referred to speech therapy on 3-11-11. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents with a level two diagnosis have the potential to be affected by the same deficient practice. The Social Service Director and Alzheimer's Unit Director reviewed residents PAS/RR paperwork to identify all facility residents that are currently a level two and ensure recommendations are being followed. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** The Social Service Director and Alzheimer's unit Director were re-in-serviced on 4/1/2011 regarding the following: PAS/RR recommendations Specialized Communication Rehab Services.	04/08/2011

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	diagnosis. The Annual Resident Review and PAS/RR (Preadmission Screening and Resident Review) Nursing Facility certification, completed 10/24/10, was reviewed. One of the recommendations indicated: "It is recommend that (resident's name) be referred for a communication evaluation and alternative communication training." Review of the record indicated there was no communication evaluation completed for the resident. Interview with LPN #3 on 3/11/11 at 7:15 a.m., indicated the resident can state one word answers or statements such as "cold" if she is cold. She indicated the resident was not able to verbalize complete sentences. Interview with The Alzheimer's Unit Director on 3/11/11 at 10:05 a.m., indicated the resident had not been referred to Speech Therapy for a communication evaluation or for alternate communication training. The Alzheimer's Unit Director indicated the resident should have been referred to Speech Therapy as recommended by the Annual Resident Review.		The Social Service Director and Alzheimer's Unit Director will meet quarterly at the scheduled care plan meeting to review residents PAS/RR paperwork to ensure recommendations are being followed. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; Quarterly the Administrator/ designee will review five residents' records to ensure any recommendations on the PAS/RR paperwork is carried out. The Administrator /designee will present a summary of the audits to the Quality Assurance committee monthly for three months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed:** April 8,2011	

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	155469	A. BUILDING _____ B. WING _____	03/14/2011

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	3.1-22(a)			

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F0441 SS=E	Based on record review and interview, the facility failed to ensure tuberculin skin testing was completed prior to employment for 2 of 5 employees hired in the last 120 days. This deficient practice had the potential to affect 119 of the 119 residents residing in the facility. (LPN #4 and CNA #5) Findings include: The facility policy titled "Tuberculosis, Employee Screening for" was received from the Nurse Consultant on 3/14/11 at 10:40 a.m. The Nurse Consultant indicated the policy was current. The policy had a revised date of April 2007. The policy indicated newly hired employees were to be screened for TB (Tuberculosis) infections and disease after an employment offer has been made but prior to the employee's duty assignment. The facility employee files were reviewed on 3/14/11 at 8:00 a.m. LPN #4 was hired on 11/29/10. The first documented TB (Tuberculin) skin test administered to the LPN was on 1/24/11. CNA #5 was hired on 1/10/11. The first documented TB skin test administered to the CNA was on 1/24/11. When interviewed on 3/14/11 at 10:45 a.m., the facility Nurse Consultant indicated the TB tests were not administered prior to or at the time of hire for the above employees. When interviewed on 3/14/11 at 11:50 a.m., the facility Administrator indicated the TB tests were not administered prior to or at the time of hire for the above employees. 3.1-14(t)(1)	F0441	**F441 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No corrective actions can be made for L.P.N. 4 and C.N.A. 5 **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All facility staff have the potential to be affected by the same deficient practice. The evening shift supervisor audited all new hires this month to ensure that the employees TB test is administered after an employment offer has been made but prior to the employee's duty assignment. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** The facility designated the evening shift supervisor in charge of the staff TB program. The HR Director will ensure that the staff members first step TB is administered after an employment offer has been made but prior to the employee's duty assignment. The HR Director is to communicate to the evening shift supervisor weekly and provide a list of all newly hired staff. The evening shift supervisor will ensure that the first step TB is read, the second step is	04/08/2011

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			completed, and the paperwork is returned to the HR Director. Licensed nursing staff and the HR Director have been in serviced on the facility's system regarding obtaining newly hire staffs tuberculin skin testing with emphasis given on the importance of administering the TB test after an employment offer has been made but prior to the employee's duty assignment. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; The DON/designee will review five newly hired staffs files a month to ensure that the TB test was administered after an employment offer has been made but prior to the employee's duty assignment. The DON/designee will present a summary of the audits to the Quality Assurance committee monthly for three months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed:** April 8, 2011	

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F0465 SS=B	Based on observation and interview, the facility failed to ensure a sanitary environment was maintained in the kitchen related to an accumulation of dust and grease on fans and on top of ovens and steamers on 2 of 2 kitchen observations with the potential to affect all dietary staff and 114 of 119 residents. Findings include: 1. During the initial Kitchen Sanitation Tour on 3/7/11 at 8:49 a.m., the fan located next to the dish area, had an accumulation of dust on the cover. Interview with the Dietary Food Manager at the time, indicated the fan cover was in need of cleaning. 2. During the Kitchen Sanitation Tour on 3/11/11 at 2:10 p.m., with the Dietary Food Manager, an accumulation of dust was observed on top of the convection oven. There was also an accumulation of dust on top of the steamer and the surface was sticky to touch. Interview with the Dietary Food Manager at the time, indicated the top of the convection oven and the steamer needed to be wiped down.	F0465	**F 465** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The cover from the fan located next to the dish area and the tops of the ovens and steamers were cleaned. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents who receive foods and or fluids from the kitchen have the potential to be affected by the same deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** The Food Service Manager/designee re- inserviced the dietary staff on 4/3/2011 regarding the importance of following the cleaning schedule in order to keep the kitchen clean, dust free, and a sanitary environment. Dietary staff will be instructed to sign or initial the log when a duty is complete. How the corrective action(s) will	04/08/2011

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	3.1-19(f)		be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; The Food Service Manager/designee will audit the kitchen at least weekly by and follow up with any concerns identified. The Food Service Manager/designee will present a summary of the audits to the Quality Assurance committee monthly for three months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed:** April 8,2011	

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F0505 SS=D	Based on record review and interview, the facility failed to promptly notify the resident's physician of abnormal ammonia level for 1 of 10 residents reviewed for unnecessary medications in the sample of 39. (Resident #121) **Findings include:** **The record for Resident #121 was reviewed on 3/9/11 at 11:00 a.m. Review of the laboratory results indicated an** ammonia level was completed on 3/4/11 at 7:34 a.m., at the hospital. The ammonia level reading was 189 a high result (11-55) normal. The results were completed on 3/4/11 at 8:52 a.m. Review of Physician orders, dated 3/7/11, indicated another ammonia level was to be done on 3/11/11 at the hospital. Review of the bottom of lab page indicated "MD (physician) aware at 10:00 a.m., new orders received." Interview with LPN #1 on 3/14/11 at 12 p.m., indicated that she did not notify the resident's physician until 3/7/11 of the abnormal ammonia level. She also indicated the labs results could have been obtained on 3/4/11 by calling the hospital lab. Interview with the Assistant Director of Nursing (ADoN) on 3/10/11 at 8:08 a.m., indicated since the lab was done at the hospital nursing staff needed to call the hospital and get the results. She indicated the hospital does not fax the facility the results and it was the nurse's responsibility to call the hospital and get the results. The ADoN indicated her expectations for nurses were to	F0505	**F 505 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** R 121s Physician was made aware of the ammonia level results. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents who have orders for labs to be drawn outside the facility at the hospital have the potential to be affected by the same deficient practice. The licensed nurse who cared for R 121 when returned from his ammonia level lab draw from the hospital was in serviced individually on the importance of obtaining and reporting the ammonia level results timely and documenting the lab results/ physician response in the nurses notes. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** The A.D.O.N. has developed a calendar to follow up on residents with orders for labs drawn outside the facility at the hospital to ensure the lab results are obtained and reported to the physician timely. Licensed nursing staff were in serviced on the importance of: · obtaining lab results drawn outside the facility	04/08/2011

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	call the same day the lab was drawn for the results. **3.1-49(f)(2)**		at the hospital timely by calling the hospital lab when the resident returns to the facility. · reporting the lab results timely to the physician · documenting the lab results with the physician response in the nurses notes instead of on the lab report. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; The ADON/designee will audit 5 residents with orders for labs obtained outside the facility at the hospital every week to ensure that the lab results are obtained and reported to the physician timely. The ADON/designee will present a summary of the audits to the QA committee monthly for three months. Thereafter, if determined by the QA committee, auditing and monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be ongoing. **Date by which systemic corrections will be completed:** April 8, 2010	

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F0514 SS=D	Based on observation, record review and interview, the facility failed to maintain clinical records that were complete and accurately documented related to documentation of a skin rash for 1 of 3 residents who met the criteria for non-pressure related skin conditions in the sample of 39. (Resident #48) Findings include: On 3/8/11 at 1:55 p.m. and 3:45 p.m., Resident #48 was observed to have a red rash to his face, arms and back of neck. On 3/9/11 at 8:30 a.m., 10:55 a.m., and 1:15 p.m., the resident's face and arms were observed to have a red discoloration. The record for Resident #48 was reviewed on 3/8/11 at 2:01 p.m. A physician's order dated 11/12/09 and listed on the 3/11 Physician's Order Summary, indicated the resident was to have Triam 0.1% cream applied twice daily to the affected areas. The 2/24/11 Comprehensive Skin Assessment, indicated no areas of breakdown were noted and to continue treatment for rash over body.	F0514	**F 514 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** R 48's Bath and Skin Report Sheet reflects he has a rash. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** Any resident who has a rash has the potential to be affected by the same deficient practice. Immediately, the ADON in serviced staff when made aware. An audit was completed to identify other residents with rashes. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Nursing staff was in serviced on how to complete the Bath and Skin Report Sheet with emphasis given to: ensuring skin conditions that continue such as a rash remains documented on accurate documentation. Ensuring the Bath and Skin Report Sheet is reflective of the resident, residents' current treatment orders and residents plan of care. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance	04/08/2011

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	A plan of care, dated 3/7/11, indicated the resident had a rash to the back, legs, and arms. Review of 3/11 Treatment Administration Record (TAR), indicated the Triam cream had been signed out twice daily for the month. Review of the Bath and Skin report sheets for the month of 3/11 indicated on 3/1, 3/3, and 3/7/11 the resident's skin was documented as being intact. There was no documentation of redness and/or a rash. The Bath and Skin report sheets for the month of 2/11 indicated the resident's skin was intact on 2/3, 2/7, 2/10, 2/14, 2/17, 2/21, 2/24, and 2/28/11. There was no documentation of redness or a rash. An entry in the Nursing Progress notes, dated 3/10/11 at 6 p.m., indicated treatment continued to redness, rash due to itching-body. Interview with CNA #4 on 3/10/11 at 10:15 a.m., indicated the skin sheets were to be completed on shower days. She indicated any skin issues such as a rash or skin tears, were to be documented on the sheet. The		programs will be put into place; The DON/designee will audit 10 residents' bath sheets weekly for complete and accurate documentation. A summary of the audits will be presented to the Quality Assurance committee monthly by the DON/designee for three months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed:** April 8, 2011	

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	CNA reviewed the resident's skin sheet for the month of March 2011, she indicated the resident's skin was coded as being intact. She stated the resident did have a rash and redness but it was ongoing and maybe that was why it was not documented. Interview with the ADON on 3/10/11 at 10:35 a.m., indicated there was no formal policy on how to complete the skin and shower sheets. She further indicated if the resident had an ongoing skin condition such as a rash and/or redness, it should be documented on the skin and shower sheet. **3.1-50(a)(1)** **3.1-50(a)(2)**			

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F9999	STATE FINDINGS 3.1-14 PERSONNEL (u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum if six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents to gain understanding of the current standards of care for residents with dementia. This state rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure the required three (3) hours of dementia specific training was provided annually for 19 of 88 employees who required annual in-service training. (Employees #1-#19) Findings include: The facility files for Dementia training of	F9999	**F 9999** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The facility has conducted the required hours of dementia training for the identified employees. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents have the potential to be affected by the same alleged deficient practice. There were no additional employees identified that have not completed the required training. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** The Human Resource Director/designee will keep an ongoing audit of current employees and their current total of hours of dementia training. The Human Resource Director will ensure that newly hired employees will receive six hours of dementia training before completing orientation. The Alzheimer's Director/ designee will	04/08/2011

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	employees were reviewed on 3/14/11 at 9:00 a.m. The following employees did not receive three hours of dementia specific training during 2010. Employee #1- Housekeeper hired on 6/0/09 Employee #2- Activity Aide hired on 1/4/08 Employee #3- LPN hired on 6/29/09 Employee #4- CNA hired on 9/23/09 Employee #5- LPN hired on 11/30/05 Employee #6- CNA hired on 5/22/96 Employee #7- CNA hired on 10/8/08 Employee #8- RN hired on 8/27/09 Employee #9- CNA hired on 9/23/09 Employee #10 - CNA hired on 7/22/09 Employee #11- CNA hired on 11/16/09 Employee #12- RN hired on 11/4/09 Employee #13- CNA hired on 8/4/99 Employee #14- Restorative Nurse hired on 10/12/09 Employee #15- LPN hired on 3/4/09 Employee #16 - Dietary Manager hired on 8/30/00 Employee #17- Maintenance Supervisor hired on 4/24/09 Employee #18- CNA hired on 11/28/08 Employee #19- Dietary Aide hired on 5/6/09 When interviewed on 3/14/11, the facility Administrator indicated the above		conduct additional dementia training at least quarterly. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; The Administrator/ designee will review 5 employees' records monthly to ensure that the required training is completed. The Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for three months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed:** April 8, 2011	

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	employees did not receive the required annual three hours of dementia specific training during 2010. 3.1-14(u)			